REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

In order for Queen Beauty Institute to evaluate your request for medical exemption from COVID-19 vaccination, you are required to fully and accurately complete each question in this form. This form, along with any other information submitted in support of your request, will be maintained confidentially, although the school may allow certain employees and/or agents to review the information for purposes of addressing your exemption request.

If you have an allergy to a COVID-19 vaccine or a specific medical condition that precludes the COVID-19 vaccination requirement and you seek a medical exemption from Queen Beauty Institute's COVID-19 vaccination requirement, please consult with your physician/health care provider and provide the following information.

NAME:	D.O.B.
EMAIL:	PHONE:

Please respond to the following:

1. Please describe the medical condition that prohibits you from receiving the COVID-19 vaccination, and why you're requesting a medical exemption from Queen Beauty Institute's COVID-19 vaccination policy.

Statement of Verification:

I verify that the above information is true and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request form will result in disciplinary action and expulsion from the school. I understand that my request for a medical exemption from a COVID-19 vaccination may not be granted if it lacks information, is inconsistent or incomplete, or creates undue hardship for the school. I understand that should my medical exemption request be approved, I must comply with Queen Beauty Institute's requirements for students with religious or medical exemptions

from the school's COVID-19 vaccination requirement, consistent with public health guidance. These requirements can be found in the school catalog.

NAME:	DATE:
SIGNATURE:	DATE:

FOR PHYSICIAN TO COMPLETE:

Queen Beauty Institute requires COVID-19 vaccinations for all students who wish to enroll. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html).

The individual above should not be vaccinated for COVID-19 for the following reasons: (Check all that apply)

▢ Severe allergic reaction (anaphylaxis) after a previous dose or to a component of a COVID-19 Vaccine

▢ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine

Please identify which ingredient caused a reaction:

Please describe the nature of the reaction:

▢ Other medical reason explained below:

Which brand of the COVID-19 vaccination is contraindicated and why?

I certify that the individual requesting medical exemption from COVID-19 vaccinations is my patient and their contraindications do prove them medically exempt from COVID-19 vaccinations. I indicate that the information contained in this request is accurate and true to the best of my ability. I understand that if I knowingly make any false statement herein, I am subject to possible penalties.

Physician Name:	License Number:
Physician Signature:	Date: